



REQUEST FOR ACCOMMODATION

Employee/Applicant

Employee/Applicant's Name:

Position:

Address:

City/State:

Zip Code:

Work Location:

Work Telephone:

Date of Request for Accommodation:

Accommodation Request

Please print or type. Be as specific as possible. If required, attach additional comments.

The attached documentation provided by my health care provider certifies the need for the requested accommodation.

Employee/Applicant's Signature: _____ Date: _____

For Office Use Only

Date Request Received: _____

Action Taken: _____

Administrative Official's Signature: _____ Date: _____

Copy to:

- ☐ ADA Coordinator
☐ Office of Fair Practices